OLR Bill Analysis

sHB 5500

AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.

SUMMARY:

This bill makes several changes in the Department of Social Services' (DSS) Medicaid provider audit process. Specifically, it:

1. limits the information the DSS commissioner or a DSS-contracted auditor may access during an audit of service providers;

2. limits the types of claims the commissioner and auditors may use to extrapolate the incidence of overpayments or underpayments based on clerical errors (i.e., determine an unknown value by projecting the results of a sample of claims a provider submitted during a specific time);

3. in determining which providers to audit, requires the DSS commissioner to select those with a higher compliance risk based on past audits;

4. eliminates a requirement that claims on which extrapolation is used have an aggregate value of at least $150,000 on an annual basis; and

5. allows an audited provider to present evidence to the commissioner or an auditor to refute the audit's findings.

The bill also requires DSS to (1) provide free provider training on how to enter claims to avoid clerical error and (2) post information on the DSS website about the auditing process and ways to avoid clerical errors.

By October 1, 2014, the bill also requires the DSS commissioner to

(1) meet with dental profession representatives about billing, record-keeping procedures, dental profession standards, and any audit process modifications concerning dental providers that may be necessary and federally permissible and (2) ensure that DSS or any DSS-contracted auditor, during an audit, has on staff or consults with a medical or dental professional experienced in the treatment, billing, and coding procedures of the provider being audited.

EFFECTIVE DATE: July 1, 2014

DSS SERVICE PROVIDER AUDITS

Limits on Information Access

The bill limits the information the DSS commissioner or any entity with whom he contracts to conduct a service provider audit can access during an audit to information relevant to the audit. Such information includes (1) services and goods the provider provided and billed to Medicaid during the period the audit covers, (2) the medical necessity (see BACKGROUND) of the services and goods, and (3) whether the provider billed responsible third parties for them. It does not include information that is confidential or illegal to disclose.

Provider Audit Prioritization and Claim Extrapolation

The bill requires the DSS commissioner to prioritize which service providers to audit. It does so by requiring him to first select providers with a higher compliance risk based on past audits or errors. It also limits, to the extent reasonably feasible, the commissioner's and any DSS-contracted auditor's use of extrapolation of underpayments or overpayments based on a clerical error to similar claims, including those billed under the same medical billing code.

The bill also broadens the circumstances in which DSS or a DSS-contracted auditor may base a finding of provider overpayment or underpayment on extrapolated projections. Under current law, such findings cannot be based on extrapolated projections unless (1) there is a sustained or high level of payment error involving the provider, (2) the provider has failed to correct the level of payment error despite documented educational intervention, and (3) the claims' aggregate

value exceeds $150,000 on an annual basis. The bill eliminates the $150,000 aggregate value minimum, thereby allowing extrapolation for any amount.

Evidence to Refute Audit Findings

By law, the DSS commissioner or any DSS-contracted auditor, after issuing a preliminary report, must hold an exit conference with an audited provider to discuss the report. The bill allows the audited provider to present evidence at the exit conference that refutes the report's findings.

BACKGROUND

Medical Necessity

"Medical necessity" means those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate a person's medical condition, including mental illness, or its effects, in order to attain or maintain the person's achievable health and independent functioning. The services must be consistent with generally accepted medical practice standards based on (1) credible scientific evidence published in recognized peer-reviewed medical literature, (2) physician-specialty society recommendations, (3) the views of physicians practicing in relevant clinical areas, and (4) any other relevant factors.

The services must also be:

1. clinically appropriate in terms of type, frequency, timing, extent, and duration and considered effective for the person's illness, injury, or disease;

2. not primarily for the convenience of the person, the person's health care provider, or other health care providers;

3. not more costly than alternative services at least as likely to produce equivalent therapeutic or diagnostic results for the person's illness, injury, or disease; and

4. based on an assessment of the person and his or her medical

condition (CGS § 17b-259b).

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 17 Nay 0 (03/20/2014)